REVISED

CHILDREN'S HEALTH INSURANCE PROGRAM ANNUAL REPORT 2001

October 1, 2000 through September 30, 2001

JAMES E. MCGREEVEY, GOVERNOR

GWENDOLYN LONG HARRIS, ACTING COMMISSIONER — DEPARTMENT OF HUMAN SERVICES

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Submitted: **February 15, 2002**

ACKNOWLEDGEMENTS

The CHIP annual report for the NJ FamilyCare program was prepared with the assistance of a dedicated staff of professionals. The Office of NJ FamilyCare would like to especially thank the following individuals for their contribution to the completion of the report.

- *Deborah C. Bradley, Acting Director, DMAHS*
- *Kathryn Plant, Deputy Director, DMAHS*
- *Michelle Walsky, Chief of Operations, DMAHS*
- *David Lowenthal, Chief, Bureau of Financial Reporting, DMAHS*
- *Sander Kelman, Chief, Bureau of Statistical Analysis and Managed Care Reimbursement, DMAHS*
- *Susan Welsh, Chief, Bureau of Managed Care Monitoring, DMAHS*
- *Elena Josephick, Administrator, Office of Eligibility Policy, DMAHS*
- *Nancy Scarlata, Administrator, Bureau of Eligibility Operations, DMAHS*
- *Dennis Doderer, Deputy Assistance Director, Premium Support Program, DMAHS*
- *Theresa Vanderheiden, Director of Marketing and Vendor Management, Office of Managed Health Care, DMAHS*
- *Thomas D. Eldershaw, Contract Administrator, Office of Managed Health Care, DMAHS*

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- *Rebecca Bivens, Support Staff*
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- *Barbara Lloyd, Outreach Coordinator*
- *Meghan Matacera, Outreach Coordinator*
- *Heidi J. Smith, Executive Director*
- *Diane Tartaglia, Outreach Coordinator*

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **New Jersey**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

_____
(Signature of Agency Head)

SCHIP Program Name(s): **NJ FamilyCare**

SCHIP Program Type:
____Medicaid SCHIP Expansion Only
____Separate SCHIP Program Only
_**X**_ Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: **February 15, 2002**

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program Eligibility:

No change

B. Enrollment Process:

See O. Contractor

C. Presumptive Eligibility:

NJ FamilyCare continues to offer presumptive eligibility for children. Children are eligible for presumptive eligibility in families with income equal to or less than 200% of the FPL (Plans A, B and C). As of April 2, 2001, NJ FamilyCare no longer offers presumptive eligibility for the adult portion of the program. Please see section 2.1 on family coverage for more information on presumptive eligibility for adults.

D. Continuous Eligibility:

No Change

E. Outreach/marketing campaigns:

Please see section 2.4 and section 3

F. Eligibility determination process:

No change

G. Eligibility redetermination process:

Effective September 2001, the County Boards of Social Service (CBOSS) began processing renewal applications for children and parents up to 150% of the FPL. Since the inception of the program the CBOSS were only able to process Plan A applications, all other applications were referred to the statewide eligibility determination agency. This change only applies to Plan A cases that are currently under the supervision of the CBOSS. When the family renews their application and the county has determined the case is no longer eligible for Plan A Medicaid coverage up to 133% FPL, but the children and parents now qualify up to 150% FPL (Plan B) they continue the renewal process. Since, coverage under Plan B requires managed care enrollment at time of eligibility; these cases must have already been enrolled in a managed care plan. Beneficiaries will be provided with a ten-day written notice advising them of the change in coverage, which includes a description of services.

An amendment to the state eligibility vendor contract included the development of a retention unit. This unit is responsible for early interactions with the newly enrolled family to assess and ensure customer satisfaction to ultimately promote retention. Ten employees will staff this unit, this includes 3 Health Benefit Coordinators (HBC), 1 Supervisor and 6 field staff to do home visits. This unit will be responsible for contacting the families who have been enrolled at least 6 months to assess customer satisfaction and at 10 months, prior to the end of their twelve month period of eligibility, they outreach the family to advise them that their renewal information will be arriving and stress the importance of completing the renewal application and returning it promptly. This unit will have follow up contact with non-respondents and use their field staff to do home visits to families having difficulty responding. This unit will also generate reports, letters to families and compile data associated with the surveys they've conducted and data gathered. State staff on a bi-monthly basis will monitor this unit.

H. Benefit Structure:

The New Jersey Division of Medical Assistance and Health Services (DMAHS) has provided mandatory managed care services to its AFDC/ TANF and NJ FamilyCare population since 1995 and 1998 respectively. As of October 2001, the HMO contract was modified, and in July 2001 it was amended further. Below are the current benefits offered to the NJ FamilyCare recipients enrolled in Plans A, B, C, and D.

NJ FAMILYCARE
PLAN A SERVICE PACKAGE

NOTE: Any family member or adult who receives this plan is entitled to fee-for-service until enrollment in managed care.

Services available through the Health Maintenance Organization (HMO) or through prior approval by the HMO

- Primary and specialty Care
- Preventive Health Care and Counseling
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Services, including non-legend drugs, ventilator services in the home, and private duty nursing when indicated as a result of an EPSDT screening.
- Emergency Medical Care
- Inpatient Hospital Services, Including acute care, rehabilitation and special hospitals
- Outpatient Hospital Services
- Laboratory Services
- Radiology Services – Diagnostic and Therapeutic
- Prescription Drugs – legend and non-legend covered by the Medicaid program, excluding clozapine, risperidone, olanzapine, quetiapine, methadone, and their generic equivalents
- Family Planning Services and Supplies
- Audiology Services
- Inpatient Rehabilitation Services
- Podiatrist Service
- Chiropractor Services
- Optometrist Services
- Optical Appliances
- Hearing Aid Services
- Hospice Agency Services
- Durable Medical Equipment (DME)/ Assistive Technology Devices
- Medical Supplies
- Prosthetics and Orthotics
- Dental Services
- Organ Transplants – both inpatient and outpatient services for donor and recipient
- Transportation Services, including ambulance, MICUs and invalid coach
- Post-acute care – Services rendered at an acute care hospital or nursing facility for 30 days or less for inpatient rehabilitation services and provided by a Medicaid participating provider.
- Home Health Agency Services

Services available fee-for-service (FFS)

- Personal Care Assistant Services
- Medical Day Care
- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech

Pathology
- Abortions and Related Services
- Transportation – lower mode
- Sex abuse examinations
- Services provided by New Jersey Mental Health/Substance Abuse and DYFS Residential Treatment Facilities, Group Homes, or Assisted Living Settings. Medical care required by these residents remains the HMO's responsibility, providing the HMO's provider network and facilities are utilized.
- Family Planning Services and Supplies – These services are both HMO covered services and also may be covered by the FFS program at the enrollee's option. Medicaid providers may bill the FFS program directly.
- Mental Health Services for all non-DDD beneficiaries
- Substance Abuse: Covered for all non-DDD beneficiaries
- Costs for Methadone and its administration: Covered for all non-DDD beneficiaries
- Clozapine, risperidone, olanzapine, quetiapine and generically-equivalent drug products
- Up to 12 inpatient hospital days when required for social necessity
- DDD/Community Care Waiver special waiver services such as case management and social work services.
- Nursing Facility care
- Inpatient psychiatric services for individuals under 21 or over 65
- Intermediate Care Facility/Mental Retardation (ICF/MR)

Note:
The NJ FamilyCare "Plan A" service package shall contain those services described in N.J.A.C. 10:49-5.2 except that long term care services shall be restricted to individuals who would qualify for programs for the aged, blind and disabled under Medicaid but for Federal immigration residency restrictions and/or categorical requirements.

NJ FAMILYCARE
PLAN B SERVICE PACKAGE

NOTE: Any child who receives this plan is only entitled to service after enrollment in managed care.

<u>Services available through the Health Maintenance Organization (HMO)</u>
- Primary and Specialty Care
- Preventive Health Care and Counseling
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Services, including early and periodic screening and diagnosis, but only those treatment services identified in the examination that are available under the HMO's benefit package or services specified as fee-for-service.
- Emergency Medical Care
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals
- Outpatient Hospital Services
- Laboratory Services

- Radiology Services – Diagnostic and Therapeutic
- Prescription Drugs – legend and non-legend covered by the Medicaid program, excluding clozapine, resperidone, olanzapine, quetiapine, methadone, and their generic equivalents
- Family Planning Services and Supplies, when in-plan
- Audiology Services
- Inpatient Rehabilitation Services
- Podiatrist Services
- Chiropractor Services
- Optometrist Services
- Optical Appliances
- Hearing Aid Services
- Hospice Agency Services
- Durable Medical Equipment (DME)/Assistive Technology Devices
- Medical Supplies
- Prosthetics and Orthotics
- Dental Services
- Organ Transplants – Both inpatient and outpatient services for donor and recipient
- Transportation Services, including ambulance, MICUs, and invalid coach
- Post-acute care – Services rendered at an acute care hospital or nursing facility for 30 days or less for inpatient rehabilitation services and provided by a Medicaid participating provider
- Home Health Agency Services

Services available fee-for-service (FFS)

- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Pathology, limited to 60 days per type of therapy per year
- Abortions and Related Services
- Sex abuse examinations
- Services provided by New Jersey Mental Health/Substance Abuse and DYFS Residential Treatment Facilities, Group Homes, or Assisted Living Settings. Medical care required by these residents remains the HMO's responsibility, providing the HMO's provider network and facilities are utilized
- Family Planning Services and Supplies – These services are both HMO covered services and also may be covered by the FFS program at the enrollee's option. Medicaid providers may bill the FFS program directly.
- Mental Health Services
- Substance Abuse Services for all non-DDD beneficiaries.
- Costs for Methadone and its administration
- Clozapine, risperidone, olanzapine, quetiapine, and generically-equivalent drug products
- Up to 12 inpatient hospital days, when required for social necessity

NJ FAMILYCARE
PLAN C SERVICE PACKAGE

NOTE: Any family with a child/children enrolled in this plan is required to pay a $15.00 monthly premium and is only eligible for service after enrollment in managed care. Premiums and co-payments are required for families and children with income greater than 150% of the Federal poverty level.

Services available through the Health Maintenance Organization (HMO)

- Primary and Specialty Care, $5 co-pay
- Preventive Health Care and Counseling
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Services, including early and periodic screening and diagnosis, but only those treatment services identified in the examination that are available under the HMO's benefit package or services specified as fee-for-service.
- Emergency Medical Care, $10 co-pay for non-emergency services
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals
- Outpatient Hospital Services, $5 co-pay, except for preventive services
- Laboratory Services
- Radiology Services – Diagnostic and Therapeutic
- Prescription Drugs – legend and non-legend covered by the Medicaid program excluding clozapine, risperidone, olanzapine, quetiapine, methadone, and their generic equivalents, $5 co-pay for brand name drugs and $1 co-pay for generic drugs
- Family Planning Services and Supplies, if in-plan
- Audiology Services
- Inpatient Rehabilitation Service
- Podiatrist Services, $5 co-pay, except for routine care
- Chiropractor Services, spinal manipulation only, $5 co-pay
- Optometrist Services, $5 co-pay
- Optical Appliances
- Hearing Aid Services
- Hospice Agency Services
- Durable Medical Equipment (DME)/Assistive Technology Devices
- Medical Supplies
- Prosthetics and Orthotics
- Dental Services, $5 co-pay, except for preventive services
- Organ Transplants – both inpatient and outpatient services
- Transportation Services, including ambulance, MICUs, and invalid coach
- Post-acute care – Services rendered at an acute care hospital or nursing facility for 30 days or less for inpatient rehabilitation services and provided by a Medicaid participating provider
- Home Health Agency Services

Services available fee-for-services (FFS)

- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Pathology. For Plan C, limited to 60 days per type of therapy per year, except for school-based rehabilitation services
- Abortions and Related Services
- Sex abuse examinations
- Services provided by New Jersey Mental Health/Substance Abuse and DYFS Residential Treatment Facilities, Group Homes, or Assisted Living Settings. Medical care required by these residents remains the HMO's responsibility, providing the HMO's provider network and facilities are utilized.
- Family Planning Services and Supplies – These services are both HMO covered services and also may be covered by the FFS program, at the enrollee's option. Medicaid providers may bill the FFS program directly.
- Home Health Agency Services
- Mental Health Services
- Substance Abuse Services
- Costs for Methadone and its administration
- Clozapine, risperidone, Olanzapine, quetiapine, and generically-equivalent drug products
- Up to 12 inpatient hospital days, when required for social necessity

NJ FAMILYCARE
PLAN D SERVICE PACKAGE

NOTE: Any family member or adult enrolled in this plan is required to pay a monthly premium and is only eligible for service after enrollment in managed care. Premiums and co-payments are required for families and children with income greater than 150% of the Federal poverty level.

Services available through the Health Maintenance Organization (HMO)

- Primary and Specialty Care, $5 co-pay, except for preventive services
- Well child care, including immunization, and lead screening and treatments
- Emergency Room Services, with $35 co-pay for non-emergency treatment
- Family Planning Services and Supplies, including: Medical history and physical exams, diagnostic and laboratory tests. Drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling
- Home Health Care Services, limited to skilled nursing care for a home-bound beneficiary which is provided or supervised by a registered nurse when the purpose of the treatment is skilled care necessary for the treatment of the beneficiary's medical condition
- Hospice services
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals
- Outpatient Hospital Services, including outpatient surgery, $5 co-pay except for preventive services
- Laboratory Services, $5 co-pay
- Radiology Services – Diagnostic and Therapeutic, $5 co-pay
- Optometrist Services: including one routine eye examination per year, $5 co-pay
- Optical Appliances: Limited to one pair of glasses (or contact lenses) per 24 month period,

or as medically necessary
- Organ Transplants
- Prescription Drugs, excluding over-the-counter drugs, $5 co-pay for brand name drugs and $1 co-pay for generic drugs
- Dental Services, limited to preventive dental services only for children under the age of 12 years; including oral exams, oral prophylaxis, and topical application of fluorides
- Podiatrist Services, excluding routine hygienic care of feet in the absence of a pathological condition, $5 co-pay
- Prosthetic Appliances, limited to initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect
- Private Duty Nursing, when authorized by the HMO
- Transportation Services, limited to ambulance services for medical emergency only
- Maternity and related newborn care
- Diabetic Supplies and Equipment

Services available fee-for-service (FFS)

- Abortion Services
- Skilled Nursing Facility Services
- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Pathology: Limited to: 1) non-chronic conditions and acute illnesses and injuries; and 2) 60 consecutive day period per incident of illness or injury beginning with the first day of treatment per contract year. Speech therapy rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects, is not covered.
- Inpatient Hospital Services for Mental Health; including psychiatric hospitals, limited to 35 days per year
- Outpatient Benefits for Short-Term, Outpatient Evaluative and Crisis Intervention, or Home Health Mental Health Services, limited to 20 visits per year, $25 co-pay:

    1. When authorized by DMAHS, one (1) mental health inpatient day may be exchanged for up to four (4) home health visits or four (4) outpatient services, including partial care. Limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits.
    2. When authorized by DMAHS, one (1) mental health inpatient day may be exchanged for two (2) days of treatment in partial hospitalization up to the maximum number of covered inpatient days.

- Inpatient and Outpatient Substance Abuse: Limited to detoxification, $25 co-pay for outpatient visits.

Note: Co-pays are not required for General Assistance and for parents with income up to 150% of the Federal Poverty Line.

I. Cost-sharing policies:

New Jersey is currently preparing a cost sharing exemption for the American Indians and Alaska Natives (AI/AN), based on the Federal tribal relationship and responsibility for protection of this specific group. NJ FamilyCare has prepared a list of children currently enrolled in the program who have self-identified as AI/AN's and are in a plan that requires cost sharing.

J. Crowd-out policies:

Please see section 2.3

K. Delivery System:

As of December 2000, Aetna US Healthcare, one of the six contracted HMO's, halted enrollment in Gloucester County because they met the network capacity for that county. Maximus, the eligibility vendor, and all application assistance sites in Gloucester and the surrounding counties of Salem and Camden were made aware of this change and encouraged to notify all appropriate staff. Families did not report any problems with accessing care.

As of August 1, 2001 Aetna US Healthcare sold its Medicaid managed care business to Americhoice Corporations, also one of our six participating HMOs. As of August 1, 2001 we now have five participating HMOs. NJ FamilyCare continues to have at least two HMOs available in every county. Some counties have representation from all five contracted HMOs.

Prior to the discontinuation of Aetna US Healthcare, all beneficiaries enrolled in this HMO were given the opportunity to select another HMO. On August 1, 2001 all Aetna US Healthcare members were automatically transferred to Americhoice unless they had elected to enroll in one of the four other managed care companies that participate in the program. These companies are Horizon Mercy, Amerigroup of New Jersey, University Health Plan and Physicians Health Services. To guarantee that this did not affect the beneficiary's ability to access quality healthcare, Americhoice honored all Aetna US Healthcare referrals for at least 30 days after the family became an Americhoice member. Many of the Aetna US Healthcare doctors and dentists were in the Americhoice network. However, if a Primary Care Physician was not participating with Americhoice, Americhoice made every effort to make them a part of their network. The Office of Quality Assurance in DMAHS maintained a daily onsite presence at Americhoice for the first four weeks of the transition period. There were no quality issues noted while onsite as a result of monitoring the plan's process for complaint response and resolution.

L. Coordination with other programs (especially private insurance and Medicaid):

No change

M. Screen and enroll process:

No change

N. Application:

CMS contracted with Maximus, Inc., a health and human services consulting firm, to develop simplified notices and applications for Medicaid and SCHIP. The Maximus Center for Health Literacy and Communication Technologies reviewed the NJ FamilyCare application for readability and suitability for low literate consumers. We received constructive criticism on how we can rework this application to make it easier on our applicants. These suggested revisions are being reviewed.

O. Contractor:

In October 2000 the State awarded the Health Benefit Coordinator contract to Maximus, Inc. Initially, this three-year contract consisted of managed care education and outreach, enrolling Medicaid consumers into managed care, processing applications for NJ KidCare, premium collections, renewals and managing the toll free hotline. Not long after the start up of this contract, the State introduced the expansion of the NJ KidCare program to NJ FamilyCare and Maximus is now responsible for NJ FamilyCare related activities.

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

Mathematica Policy Research, Inc., used the adjusted estimates based on the 1997 Current Population Survey, which identified 274,475 uninsured NJ FamilyCare and Medicaid children. The total estimated number of uninsured children eligible for NJ FamilyCare is 162,766.

NJ FamilyCare is broken down into four distinct plans, plans A, B, C, and D. As of September 30, 2001 Plan A (up to 133% FPL) had 41,102 estimated eligible children and 32,876 children enrolled, reducing the percentage by 80.0%. Plan B (134%-150% FPL) had 15,729 estimated eligible children and 8,777 children enrolled, reducing the percentage of uninsured by 55.8%. Plan C (151%-200% FPL) had 37,602 estimated eligible children and 25,015 children enrolled, reducing the percentage by 66.5%. Plan D (201%-350% FPL) had 68,334 estimated eligible children and 13,326 children enrolled, reducing the percentage of uninsured by 19.5%. As of September 1, 2001 the NJ FamilyCare program had a total of 79,994 children enrolled, reducing the percentage of uninsured by 49.1%.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

From program inception through September 2001, 89,164 Medicaid eligibles have enrolled as a result of NJ FamilyCare publicity, which would not have otherwise been enrolled. This estimate is based on a longitudinal analysis of Medicaid child enrollment before and after the start of the SCHIP program. As can be seen on the chart below, Medicaid children were growing at a steady monthly rate of approximately 740, up through January 1998 and a similarly steady rate of almost 3,000 since that time. Because the change was so abrupt at exactly the start date of the SCHIP program, the elevated growth rate is so steady thereafter, and no other contributing factors could be identified, we conclude that the publicity and outreach for the SCHIP program explain the increase.

Numerically, the productivity of increased Medicaid enrollment growth grew from 1.08 Medicaid children per added CHIP child enrolled in the middle of CY98 (April-September), to 1.14 in the middle of CY99 to 1.33 in the middle of CY00 to 3.78 in the middle of CY01.

Medicaid Enrollment

C. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

___X___ No, skip to 1.3

_____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

Objectives and Performance Goals
Strategic Objectives

- *Conduct an effective outreach program to ensure that individuals responsible for ensuring the health care of uninsured children are aware of the options provided in New Jersey under Title XXI.*

- *Reduce the number of uninsured children as reported in the Current Population Survey by 50%.*

- *Coordinate enrollment with Title XIX to ensure coverage for children previously eligible but not enrolled in the Medicaid program.*

- *Ensure the provision of high quality care that is sensitive to the needs of the beneficiary as evidenced by beneficiary satisfaction surveys.*

- *Provide access to a health care plan with a network adequate to meet the needs of the enrolled children.*

- *Ensure that enrolled children have access to primary and preventive care services, with a special emphasis on hard to reach populations such as adolescents.*

- *Ensure that the enrolled children are actually utilizing available services.*

- *Improve health outcomes for children as measured by certain key indicators.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Reduced percentage of low-income uninsured children	• Reduced percentage of uninsured children by 50%	Data Source: Mathematica Policy Research, inc. Methodology: The adjusted estimates based on the 1997 Current Population Survey identified 274,475 uninsured NJ FamilyCare and Medicaid children. The estimated number of uninsured children eligible for NJ FamilyCare is 162,766. Progress Summary: NJ FamilyCare is broken down into four distinct plans, plans A, B, C, and D. As of September 30, 2001 Plan A (up to 133% FPL) had 41,102 estimated eligible children and 32,876 children enrolled, reducing the percentage by 80.0%. Plan B (134%-150% FPL) had 15,729 estimated eligible children and 8,777 children enrolled, reducing the percentage of uninsured by 55.8%. Plan C (151%-200% FPL) had 37,602 estimated eligible children and 25,015 children enrolled, reducing the percentage by 66.5%. Plan D (201%-350% FPL) had 68,334 estimated eligible children and 13,326 children enrolled, reducing the percentage of uninsured by 19.5%. As of September 1, 2001 the NJ FamilyCare program had a total of 79,994 children enrolled, reducing the percentage of uninsured by 49.1%.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
Enrollment	• Number of uninsured children as reported in the Current Population Survey • Number of Children enrolled	Data Source: Extract from the Recipient History Master file: NJMMIS Methodology: Number of enrolled children reported on the system by September 27, 2001. Progress Summary: 79,994 were enrolled in the program as of September 27, 2001 (this number reflects a point in time).
Employ user friendly enrollment process	• % of applications requested that are completed and returned	Data Source: HBC vendor monthly activity reports Methodology: Applications requested from NJ FamilyCare toll free number. Progress Summary: From September 2000 through September 28, 2001, 85,783 NJ FamilyCare applications were requested. The number received is captured from when Maximus began processing applications in January 2001. Maximus received 76,339 applications from January 8, 2001 through September 28, 2001.
Employ user friendly enrollment process	• Rating of process as part of the customer satisfaction survey	Progress Summary: The 2001 CAHPS Survey was conducted throughout the summer. Children enrolled in NJ FamilyCare were included in this years CAHPS survey, which rates the customer's satisfaction with the HMO's, Physicians, and the HBC enrollment process.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
Employ user friendly enrollment process	• Track number of complaints regarding enrollment process	Data source: Monthly report from the HBC contractor detailing all phone call and letters received from NJ FamilyCare clients Methodology: number of complaints received by the hotline and mail received. Progress Summary: The HBC eligibility vendor received 1,137 complaints from January 2001 through September 30, 2001. Due to the overwhelming response to the program the majority of the complaints received were due to the backlog of applications and the long wait time on the NJ FamilyCare hotline. NJ FamilyCare evaluates complaints in a timely manner, monitors incoming calls, and makes procedural changes when necessary. (This number captures the number of complaints received when Maximus, Inc. began the health benefits contract in January 2001.)
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Must reach target population	Number of enrolled children in Title XXI by age, income, race/ethnic category	Data Source: HBC vendor monthly reports Progress Summary: A monthly report is generated by the vendor that captures age, income, race, and ethnic category. The report shows that minorities are aware of the NJ FamilyCare program and have enrolled. It captures six categories by ethnicity: Asian, Black, Hispanic, American Indian/Alaskan Native, White, and Other.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
Must reach target population	Increased enrollment under Medicaid	Progress Summary: From program inception through September 2001, 89,164 Medicaid eligibles have enrolled as a result of NJ FamilyCare publicity, which would not have otherwise been enrolled. This estimate is based on a longitudinal analysis of Medicaid child enrollment before and after the start of the SCHIP program. Medicaid children were growing at a steady monthly rate of approximately 740, up through January 1998 and a similarly steady rate of almost 3,000 since that time. Because the change was so abrupt at exactly the start date of the SCHIP program, the elevated growth rate is so steady thereafter, and no other contributing factors could be identified, we conclude that the publicity and outreach for the SCHIP program explain the increase.
Must be culturally appropriate	Number of non English speaking beneficiaries enrolled	Data Source: Monthly HBC vendor reports (children by language spoken) Methodology: Information received from the application is captured in the system and reported monthly Progress Summary: The NJ FamilyCare fact sheet is available in seven languages (Polish, Korean, Spanish, Portuguese, Arabic, French, and Chinese). These languages were the top seven reported by families on the NJ FamilyCare application. The NJ FamilyCare hotline has access to the AT&T language line, which offers translations in 144 languages. Also, the hotline has a Spanish Que where Spanish-speaking callers can speak directly with a Spanish-speaking health benefits coordinator. From January 1, 2001 through September 30, 2001 955 non-English speaking beneficiaries enrolled.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
Must involve public health community	Number of public health organizations that participate in the outreach program	Data Source: Health related agencies within the Department of Health and Senior Services. Progress Summary: 12 Federally Qualified Health Centers, 19 Women, Infant, Children (WIC) Nutrition Programs, 111 Local Health Departments, 21 Special Child Health Services, and 7 Maternal Child Health Consortia are identifying and enrolling children into the program.
Must involve community based organizations	Number of CBO's that participate in the outreach program by county	Data Source: Internal database that includes the name, address, telephone number, and contact person of the agencies involved with community outreach statewide. Progress Summary: enrollment sites (400+) – CBO's, Health Care providers, schools, headstarts, day care centers and Government agencies are participating in outreach activities for NJ FamilyCare at no cost to the program. Their participation ranges from disseminating NJ FamilyCare information to assisting with completing the application. NJ FamilyCare has grant relationship with agencies to assist families with the application and enrollment process. The following are categories of the agencies involved: • Outreach enrollment grantees – 35 agencies were paid $25 for each successful household enrollment into the program. This grant was available from July 1, 1999 through June 30, 2001.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		• Head Start Agencies – 8 agencies were paid $25 for each successful household enrollment into the program. This grant was available from February 2000 through June 30, 2001. • RWJ funds – "Covering Kids" pilot – 5 agencies developed coalitions with over 25 agencies to improve methods to increase NJ FamilyCare enrollment. This grant is available through April 2002. • Current legislation allows incentives for schools, day care/child care centers, FQHC's, and local health departments to be paid a $25 incentive for assisting families in enrolling into the NJ FamilyCare program.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Ensure referral and enrollment of Medicaid eligibles	Number of individuals referred to Title XIX	Data Sources: HBC eligibility vendor monthly report Methodology: The HBC eligibility vendor or the CBOSS can process applications if a family's income is at or below the TANF limits, or has children born before October 1, 1983. If a family has an existing case at the county their application is referred to the CBOSS for an eligibility determination. Additionally, these families may qualify for other services available at the county. Progress Summary: From January 1, 2001 to September 30, 2001, 229 applications were transferred to the County Boards of Social Services. (This number captures the number of applications transferred when Maximus, Inc. began the health benefits contract in January 2001)
Ensure referral and enrollment of	Tracking enrollment of referrals into XIX	Progress Summary: HBC vendor monthly reports indicate the number of children enrolled through the CBOSS. The eligibility vendor screens for

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
Medicaid eligibles		eligibility into the Medicaid program. If an individual has an open case at the CBOSS this individual is notified of the transfer for follow-up at the county.
Ensure referral and enrollment of Medicaid eligibles	Increased percentage of Medicaid eligibles enrolled in the program as demonstrated on CPS	Progress Summary: From program inception through September 2001, 89,164 Medicaid eligibles have enrolled as a result of NJ FamilyCare publicity, which would not have otherwise been enrolled. This estimate is based on a longitudinal analysis of Medicaid child enrollment before and after the start of the SCHIP program. Medicaid children were growing at a steady monthly rate of approximately 740, up through January 1998 and a similarly steady rate of almost 3,000 since that time. Because the change was so abrupt at exactly the start date of the SCHIP program, the elevated growth rate is so steady thereafter, and no other contributing factors could be identified, we conclude that the publicity and outreach for the SCHIP program explain the increase.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Ensure network as reported by plans are actually available	% of providers (FTE) listed who are actually accepting new beneficiaries	Data Sources: Provider network submitted to DMAHS by NJ Care 2000+ HMOs for SFY 2000. Methodology: A query of unique providers Numerator: 1985 Denominator: 2265 Progress Summary: Approximately 88% of the pediatric providers in the network were accepting new beneficiaries at any given time during SFY 2000.
Pediatric Specialists	Number of specialists who limit practice to	Data Sources: Provider Network submitted to DMAHS by NJ Care 2000+ HMOs.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	pediatrics	Methodology: A query on unique provider names by specialty Progress Summary: The HMO network has 1,134 pediatricians, 2,265 pediatric specialists and 27 pediatric nurse practitioners. Additionally, the network has 950 family practitioners, 42 family nurse practitioners, 97 general practitioners and 15 CNP/CNS.
Mental Health Services	A narrative description of the plans' pediatric mental health provider network, including the number and type of Mental Health providers specially trained to treat children and adolescents	Data Source: Provider Network submitted to DMAHS by NJ Care 2000+ HMO's Methodology: A query on unique provider names by specialty Progress Summary: Mental Health services are carved out from the standard managed care benefit package. There are a total of 76 Medicaid fee-for-service Mental Health providers. The HMO network has 549 psychologists and 373 psychiatrists.
Dental Services	• A narrative description of the plans' dental provider network, including the number and type of dental providers specially trained to treat children • % primary care dentists (FTE's) • % pediatric dental	Data Sources: Provider Network submitted to DMAHS by NJ Care 2000+ HMOs Methodology: A query on unique provider names by specialty. Progress Summary: All of the HMOs have contracts with primary care dentists and specialists that include orthodontists, prosthodontists, endodontists, periodontists, and oral surgeons. They are required to maintain a primary care dental ratio of 1 per 1,500 members. The dental network has a total of 1,544 providers. The breakdown by specialty is as follows: • General Dentists: 952 • Maxillofacial Surgery: 194

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	specialists	• Orthodontist: 124 • Pedodontist: 94 • Periodontist: 80 • Endodontist: 64 • Prosthodontist: 36
Children's access to primary care providers	% of Title XXI enrolled children by age category that had a visit with a health plan primary care provider during the reporting year or the year proceeding reporting year	Data Sources: 2000 EPSDT NJ FamilyCare Focused Study based on medical record review conducted by DMAHS' external quality reviewer, the Peer Review Organization of New Jersey (PRONJ). Progress Summary: **Percentage of children 0-2 years with a well visit:** Weighted Average = 61% Unweighted Average = 68% (116/171) **Percentage of children 3-11 years with a visit:** Weighted Average = 63% Unweighted Average = 63% (387/619) **Percentage of children 12-18 years with a visit:** Weighted Average = 57% Unweighted Average = 58% (817/1405) * Unweighted average calculated by dividing the total number of children with a visit/immunization/screening by the total number of children across the six HMOs. ** Weighted average calculated by dividing the sum of the percentage of each HMO by the number of HMOs.
Well child visits in the first two years of life (ages are based on EPSDT data)	% of members who turned 2 years old during the reporting year and who receive either zero, one, two,	Data Source: PRONJ 2000 EPSDT NJ FamilyCare (0-2 year olds) Focused Study (Medical Record Review) Progress Summary: **Children up to 15 months with appropriate number of well visits:**

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	three, four, five, six, or more well child visits with a primary care provider during the first 15 months of life	Weighted Average = 15% Unweighted Average = 17% (12/71) * Unweighted average calculated by dividing the total number of children with a visit/immunization/screening by the total number of children across the six HMOs. ** Weighted average calculated by dividing the sum of the percentage of each HMO by the number of HMOs.
Well child visits in the third through the eleventh year of life (ages are based on EPSDT data)	% of members who were 3 through 11 years old during the reporting year and who received one or more well-child visits with a primary care provider during the reporting year	Data Source: PRONJ 2000 EPSDT NJ FamilyCare (3-11) Focused Study (Medical Record Review) Progress Summary: **Children 3-11 years of age with a well visit during 2000:** Unweighted Average = 35% (219/619) * Unweighted average calculated by dividing the total number of children with a visit/immunization/screening by the total number of children across the six HMOs.
Adolescent well care visits	% of members who are 12 through 18 years of age during the reporting year who have had at least one comprehensive well-care visit with a primary care provider during the reporting year	Data Source: PRONJ 2000 EPSDT NJ FamilyCare (12-18 year olds) Focused Study (Medical Record Review). Progress Summary: **Adolescents with a well visit:** Weighted Average = 27% Unweighted Average = 27% (169/615) * Unweighted average calculated by dividing the total number of children with a visit/immunization/screening by the total number of children across the six HMOs. ** Weighted average calculated by dividing the sum of the percentage of each HMO by the number of HMOs.

OTHER OBJECTIVES/ HEATLH OUTCOMES		
Childhood immunization status	% of children in plan who have received appropriate immunizations by their 2nd birthday	Data Source: HEDIS 2001 Childhood Immunization Measure submitted by HMOs to PRONJ. Only three out of six HMOs provided HEDIS rates, the PRONJ will perform a study to ascertain the rates for the plans who failed to report rates on childhood immunization using HEDIS standards. Updated rates that reflect average rates for all six plans will be forwarded to CMS as soon as it is available. Progress Summary: **Two years olds meeting combo #1** Weighted Average = 52% Unweighted Average = 52% (323/622) * Unweighted average calculated by dividing the total number of children with a visit/immunization/screening by the total number of children across the six HMOs. ** Weighted average calculated by dividing the sum of the percentage of each HMO by the number of HMOs.
Adolescent immunization status	% of 13 year olds in plan who receive all appropriate immunizations by their 13th birthday	Progress Summary: 9% of 13 year olds received their MMR, HEP B, and the VARICELLA immunizations. 14% of 13 year olds received all immunizations without the VARICELLA immunization.
Lead Screening	% of children in plan who have received appropriate lead screenings by their 6th birthday	Progress Summary: 15% (13,571/89,303) of children between 6 months and 2 years of age received blood lead screenings. For children between 6 months and 6 years of age, 20% (35,527/180,766) received blood lead screenings.

OTHER OBJECTIVES/ QUALITY-BENEFICIARY SATISFACTION WITH CARE		
Expand NJ participation in CAHPS demonstration to include all children covered under Title XXI	Adjust statistically valid samples to include Title XXI population	Progress Summary: A separate cell for children in NJ FamilyCare was developed in the 2001 CAHPS survey. 750 children from each Plan were sent CAHPS survey packets to get a response rate of at least 33% to obtain a statistically valid sample. The actual response rate for NJ FamilyCare has been 35%. The results of the CAHPS survey are currently being evaluated.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

In September 2000 New Jersey offered a state funded program that would insure uninsured parents/caretakers up to 200% FPL. As of January 2001, New Jersey was approved by CMS for an 1115 Waiver to provide family coverage under CHIP for families and pregnant women with gross income below 200% of poverty. The original design of NJ FamilyCare when fully implemented was to provide free or low cost health insurance to 125,000 adults. It was anticipated that this projected growth would be over a three-year period. As of September 30, 2001 we have enrolled 92,662 parents/caretakers.

Current eligibility groups include the following children and adults:

AFDC Medicaid Expansion

Parents and dependent children (insured and uninsured) with earned incomes at or below 133% FPL, including Medicaid Special for children to age 21;

- *Receive the same benefits as a Medicaid beneficiary enrolled in New Jersey Care 2000 managed care program*
- *The County Boards of Social Service or the state vendor can determine eligibility.*
- *Eligibility begins with established month, i.e. date of application no earlier than 9/1/00. Retroactive benefits no earlier than July 1, 2000*
- *Fee for Service benefits until enrollment into managed care*

NJ FamilyCare

Parents/caretakers of dependent children (uninsured) who do not qualify for AFDC but are below 150% FPL; parents/caretakers with unearned income below 133% FPL; including legal permanent residents regardless of date of entry;

- *Receive an adult benefits package the same as NJ FamilyCare Plan D services*
- *No monthly premium payment or co-payments*
- *The state vendor determines eligibility.*
- *Eligibility begins in the month of managed care enrollment.*

Parents/caretakers of dependent children (uninsured with income above 150% but below 200% FPL; including legal permanent residents regardless of date of entry;

- *Receive an adult benefits package the same as NJ FamilyCare Plan D services*

- *$25.00 monthly premiums for the first adult and $10.00 for the second adult, with applicable co-pays*
- *The state vendor determines eligibility.*
- *Eligibility begins in the month of managed care enrollment.*

Single adults and couples (insured and uninsured) without dependent children eligible for Work First New Jersey/General Assistance (WFNJ/GA) cash benefits;

- *Receive an enhanced medical service package similar to Medicaid benefits*
- *The County Boards of Social Service and Municipal Welfare Departments determine eligibility*
- *Able to receive covered hospital services in month of managed care enrollment.*
- *Limited Fee for Service benefits until enrollment into managed care*
- *No monthly premiums or co-payments*

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

92,662 Number of parents/caretakers
79,994 Number of children

Legal qualified immigrants, including permanent residents are eligible for the NJ FamilyCare program regardless of date of entry.

As of April 2, 2001 NJ FamilyCare no longer offers Presumptive Eligibility (PE) for adults and certain legal immigrant children (those children with dates of entry into the United States on or after August 22, 1996). The Division of Medical Assistance and Health Services expended all the funds budgeted for this purpose during State Fiscal Year 2001. PE continues to be available for children up to 200% of the federal poverty level.

Crowd Out for NJ FamilyCare

Plan A families with income under 133% FPL do not have to be uninsured before they can enroll in NJ FamilyCare. Families between 134% and 200% FPL cannot have been covered under an employer-sponsored insurance for 6 months prior to application. The waiting period has been eliminated for families paying for an individual health plan or Cobra. These families must be at or below 200% FPL. Also, exceptions will be made to the six-month requirement:

- *If prior employer coverage was lost through no fault of the family, such as, an employer went out of business or the employee was laid off or changed jobs.*
- *However, if the caregiver changed jobs and is eligible for group insurance at the new job it must be more expensive than the NJ FamilyCare rate.*
- *If the family's income is between 200-350% of the federal poverty level, and their COBRA benefits expired.*

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

The Premium Support Program is designed to assist working families enrolled in NJ FamilyCare to purchase available employer-sponsored health insurance. In addition to providing a subsidy toward the cost of the premium, this program will also pay for co-payments, deductibles and co-insurance amounts.

An employer is requested to provide the Premium Support Program with their employer plan information so that we can evaluate the feasibility of participating with that employer. The Program requires that an employer contribute at least 50% towards the family health coverage for their employees and their dependents to participate in PSP. Their company's health insurance plans must also meet certain standards for covered benefits and costs.

The PSP will ask the employer to complete a short questionnaire about the health plans available at their company. We will also ask them to provide a copy of the Benefits Summary for those plans. The family could also ask their insurance carrier to provide this information.

If the employer plan meets PSP eligibility standards the NJ FamilyCare/employee must enroll in the employer plan for family coverage. A subsidy payment to defray the cost of the health insurance payroll deduction is forwarded to the beneficiary/employee.

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

The NJFC/PSP became operational with its first enrollment on July 1, 2001. As of September 30, 2001

31 Number of adults enrolled
44 Number of children enrolled

C. How do you monitor cost-effectiveness of family coverage?

The PSP evaluates each case for cost effectiveness that is identified for participation. The cost effectiveness model was developed by an actuarial contractor and the State and uses a algorithm to compare the cost of maintaining the family in the direct care NJ FamilyCare Program compared to buying-in to the employer sponsored insurance, (ESI). If the cost is less to participate in ESI the family will participate in PSP, if not, the family remains in NJ FamilyCare without interruption. Below is a description of the formula used to compare plan participation for cost effectiveness.

The chart below provides a detailed example of the costs that will be compared as part of the cost effectiveness test.

Costs for enrollment in State Contracted Plan	Costs for Enrollment under the Premium Support Program
• **Per member per month capitation costs for each adult based on age, sex and geographic location under the State contracted plan**	• **Employee share of the monthly family premium under employer plan**
• **Actuarially determined capitation costs for all children in a family based on average family size and age of the children**	• **Actuarially determined value of wrap around payments for all family members enrolled in small employer plan (necessary to meet Plan D benchmark requirements)**
• **Actuarial value of services paid on a fee-for-service basis for each adult and all children based on average family size**	• **Actuarially determined value of wrap around payments for children necessary to meet the Plan B and C benchmark requirements**
• **Less Premium Payment based on family size**	• **Actuarially determined value of fill-in payments for excess cost sharing (copayments and deductibles) under employer plan**

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

See Crowd-Out indicator below

B. How do you monitor and measure whether crowd-out is occurring?

A section of the NJ FamilyCare application addresses the issue of existing health insurance. It asks specific questions regarding families' insurance status. The HBC Vendor monthly reports detail the number of families that are applying that currently have health insurance or had health insurance in the last 6 months.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

See Crowd-Out indicator below

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

See Crowd-Out indicator below

"Crowd-Out" Indicators

If a family were to drop employer or individual coverage they already have for their children in order to take advantage of state subsidized coverage, then the NJ FamilyCare program would result in a "crowd-out" of existing coverage. The purpose of the federal law was to provide health insurance coverage to uninsured children, not to replace existing coverage. In fact, the federal law requires states to include a description of the procedures to be used to ensure that the insurance provided under the State Child Health Plan does not substitute for coverage under group health plans. In New Jersey, the look back period serves this purpose.

Initially, the look back period for NJ KidCare Plans B and C was set at 12 months. This mirrored the look back period used under the Health Access program, a State run program that provided health insurance for uninsured families. However, when NJ FamilyCare was implemented, the Department pledged to review this policy after the program was in place and, if feasible, reduce the look back period. The culmination of this review supports the premise that dropping the period of uninsurance from twelve to six months would not markedly increase the risk of "crowd-out" or increase program costs, since it is estimated that only 6,478 additional children under the initial income categories would be eligible for the program as a result of this change.

Under NJ FamilyCare Plans B, C, and D the six-month waiting period still applies to those children who are covered under an employer-sponsored group plan. As of July 1, 1999 the waiting period has been eliminated for families purchasing health care coverage from an individual plan or COBRA. These families income must be at or below 200 percent of the FPL. Also, exceptions will be made to the six-month requirement:

- *If prior employer coverage was lost through no fault of the family, such as, an employer went out of business or the employee was laid off or changed jobs.*
- *However, if the caregiver changed jobs and is eligible for group insurance at the new job it must be more expensive than the NJ FamilyCare rate.*
- *If the family's income is between 200-350% of the federal poverty level, and their COBRA benefits expired.*

New Jersey's experience with "crowd out" of existing coverage over the last four years indicates that families are not dropping their health care coverage to become eligible for NJ FamilyCare. However, New Jersey is concerned with the possibility of employer "crowd out." The implementation of the Premium Support Program

should eradicate this concern. Currently, the Premium Support Program is working with small businesses to provide health care coverage for uninsured employees and their families. The Premium Support Program includes children in families with income up to 200% of poverty that have access to employer-sponsored insurance. Under this program, the state is helping the parent purchase employer sponsored coverage if it would cost the state less to do so than if the family were enrolled in NJ FamilyCare.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

C. Which methods best reached which populations? How have you measured effectiveness?

2000-2001 Media Analysis

Following is an analysis of paid media used between October 2000 and March 2001, to promote the NJ FamilyCare program.

Data from three sources has been used in the compilation of this analysis:

1) *The Winning Strategies 2000/2001 media schedule, showing which media were employed – and sizes or weight levels used – during each week of the campaign;*

2) *Maximus weekly statistics on the number of calls received and kits requested on a daily basis; and*

3) *Maximus weekly reports citing the source from which callers reported hearing about NJ FamilyCare.*

This analysis can provide valuable insights with regard to which media performed most effectively, and how media – overall – elicited measurable response on the part of

consumers. Several significant factors should be kept in mind, however, in the assessment of these findings.

Information used to tally the source from which callers had learned about NJ FamilyCare was determined by asking callers the following unaided question: "How did you first learn about NJ FamilyCare?". This method for tracking responses, while providing good baseline information, does not allow us to weigh numerous factors that enter into a thorough analysis of media effectiveness. These include:

1) *The synergy of the various media elements working together to create consumer awareness;*

2) *The time differential between when consumers saw/heard an advertising message and when they placed the call to request information;*

3) *Common vernacular vs. media terminology. (For example, an exceptionally high percentage or respondents answered "NJ FamilyCare Announcement". Many people refer to ads as announcements, yet it is impossible to determine the individual media vehicles to which we should attribute these responses. As a result, they are tallied with the non-media responses and vastly lower the count for advertising-driven awareness.*

4) *Similarly, "Family/Friend" received a vast number of responses. It is reasonable to conclude that many of these referring sources were impacted by the advertising campaign, but again these replies are tallied with the non-media responses.*

Additionally, the source from which respondents had heard about NJ FamilyCare was tracked for only those callers that requested kits, not from all calls received. Between October 2, 2000 and March 30, 2001, Maximus reports receiving 550,491 calls and 63,738 requests for kits. Therefore, the source for hearing about NJ FamilyCare has only been reported for 11.6% of the total responses generated.

These factors withstanding, following are the conclusions that can be drawn from the analyzed data:

- *Knowledge of the NJ FamilyCare program can be directly attributed to media sources in 19.7% of tallied responses. If all "NJ FamilyCare Announcement" and 50% of "Family/Friend" responses are added to this tally, the total rises to 51.9%.*

Stated Source	*# Responses*	*% of Total Media Responses*	*% of Total Media Spending*
Bus/Billboard	*496*	*3.9%*	*6.0%*
Magazine	*51*	*0.4%*	*0.9%*
Movie Theater	*13*	*0.1%*	*4.1%*
Newspaper	*2,250*	*17.9%*	*8.1%*
Radio	*1,664*	*13.2%*	*8.6%*
Television	*8,101*	*64.4%*	*72.3%*

- ***Bus/Billboard:*** *Accounted for 3.9% of total "media" responses and 6.0% of total media spending. As this vehicle was employed to act in a supplementary, message-reinforcing role, this is an appropriate response rate indicative of successful media application.*

- ***Magazine:*** *Accounted for 0.4% of total media responses and 0.9% of total media spending. With unaided questioning, it is difficult to know which media vehicles respondents classify as "magazines". For our purposes, parenting publications were classified as magazines due to their monthly (or longer) publishing frequency. As these publications are printed on newspaper grade paper stock, however, many respondents answering "Newspaper" may have been referring to these publications. Given their targeted audience focus, low cost and the ambiguity of the responses, we would recommend continuing the use of this vehicle in future NJ FamilyCare advertising promotions.*

- ***Movie Theater:*** *Accounted for 0.1% of total media responses and 4.1% of total media spending. This medium has garnered an extremely low response rate for two years in a row. Although it was intended as a support medium, this represents an unacceptably low response rate. As a result, we would not recommend continuing the use of this medium in future NJ FamilyCare advertising promotions.*

- ***Newspaper:*** *Accounted for 17.9% of total media responses and 8.1% of total media spending, making this the most efficient cost-per-response vehicle on the media schedule. Two factors should be kept in mind, however. As stated in the "Magazine" analysis, a portion of these responses is likely attributable to the Parenting Publications that were classified internally as magazines. Also, numerous NJ FamilyCare editorial articles ran in New Jersey newspapers, and a portion of these responses may actually be attributable to these, as opposed to newspaper advertisements. Regardless, this is an exceptionally good response and indicates that newspaper should remain a core vehicle in future NJ FamilyCare advertising campaigns.*

- ***Radio:*** *Accounted for 13.2% of total media responses and 8.6% of total media spending. This medium generated the third highest response rate, behind television and newspaper. These scores validate the use of radio as a strong delivery medium that works well in concert with TV and print and warrants continued use in future campaigns.*

- ***Television:*** *Accounted for 64.4% of total media responses and 72.3% of total media spending, making this medium the undisputed leader in generating consumer awareness. This medium garnered 3.5x more responses than newspaper, the second-ranking response generator. Broadcast television was newly added to the 2000/2001 NJ FamilyCare advertising campaign, and its inclusion significantly increased the reach of the NJ FamilyCare message. In the October 1998 – December 1999 tracking period, combined radio and cable television response garnered only 29% (Eligibility Determination Ranking) and 35% (HBC/HMO Enrollment) of total media responses, vs. 77.6% in 2000/2001. Although tracking did not measure whether ads were seen on broadcast or cable media outlets, "Television" responses rose 297% in the weeks*

surrounding broadcast television flights, vs. weeks when cable television alone was employed.

There is a perception that because New Jersey broadcast television originates from the New York and Philadelphia markets, thus delivering significant out-of-state audience "waste", it is not a prudent advertising medium for NJ-only advertising campaigns. However, with nearly 2/3 of all media-specific responses attributable to television, and an extremely reasonable spending to response ratio, its continued future use is conclusively justified.

- ***Conclusion:*** *Reviewed collectively, the media schedule employed for the 2000/2001 NJ FamilyCare advertising program garnered unprecedented consumer response. The synergy of the various media vehicles worked extremely well to deliver widespread consumer awareness and elicit exceptional levels of active response. The only media vehicle that does not indicate an acceptable return on investment is in-theater advertising. We would recommend eliminating this medium in future campaigns.*

Weekly response tracking indicates that advertising continued to have a lasting impact on initiating response, long after the ads themselves had stopped running. Although the vast majority of all advertising ended effective 12/23/00, media responses continued to deliver significant tallies for an additional ten weeks.

Following are four charts that provide further levels of media analysis detail:

1) *NJ FamilyCare 2000/2001 Media Schedule: Flowchart providing detailed information on the various media vehicles that were employed, including weeks of use, ad sizes, broadcast weights, spending by media, etc.*

2) *4th Quarter 2000 Media Analysis: Chart providing information on response tallies for each media vehicle (English and Spanish) on a weekly basis, during Q4 2000. Chart also indicates the weeks that advertising was placed in each media.*

3) *1st Quarter 2001 Media Analysis: Chart providing information on response tallies for each media vehicle (English and Spanish) on a weekly basis, during Q1 2001. Chart also indicates the weeks that advertising was placed in each media.*

4) *Total 6-Month Program Media Analysis: Chart providing information on response tallies (English and Spanish) by quarter and for the full 6-month program. Chart also includes media spending percentages.*


NJFC 2000/2001 Media Schedule


4th Quarter 2000 Media Analysis


1st Quarter 2001 Media Analysis


Total 6 Month Media Analysis

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

An amendment to the Maximus contract included the development of a retention unit. This unit is responsible for early interactions with the newly enrolled family to assess and ensure customer satisfaction to ultimately promote retention. Ten Maximus employees will staff this unit, this includes 3 Health Benefit Coordinators (HBC), 1 Supervisor and 6 field staff to do home visits. This unit will be responsible for contacting the families who have been enrolled at least 6 months to assess customer satisfaction and at 10 months, prior to the end of their twelve month period of eligibility, they outreach the family to advise them that their renewal information will be arriving and stress the importance of completing the renewal application and returning it promptly. This unit will have follow up contact with non-respondents and use their field staff to do home visits to families having difficulty responding. This unit will also generate reports, letters to families and compile data associated with the surveys they've conducted and data gathered. State staff on a bi-monthly basis will monitor this unit.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

X Follow-up by caseworkers/outreach workers
X Renewal reminder notices to all families
X Targeted mailing to selected populations, specify population – *The NJ FamilyCare retention unit is focusing on eight counties with the highest disenrollment rate.*
___ Information campaigns
X Simplification of re-enrollment process
X Surveys or focus groups with disenrollees to learn more about reasons for disenrollment,

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes the same measures are used for Medicaid cases maintained by the state vendor, as the programs are integrated. For cases maintained by the county agencies, they are outreached by mail.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

NJ FamilyCare has focused on strategies that improve renewal forms and processes that are more consumer friendly and make reenrollment easier for families. Implementation of a more passive approach to reenrollment eliminates the need to complete a new application form. New Jersey sends families a preprinted form with all the necessary information that they provided when they enrolled and requires families to review, note

any changes and submit only one-month proof of income. Providing families with a self-addressed stamped envelope produces faster and greater turnaround of completed application forms and premium collection. These envelopes are specially coded for easy identification, which helps to expedite the renewal process. A retention unit has been developed to help family's reenroll into the program. There is 10 staff members designated to follow up with families and to do home visits if necessary. The retention unit is responsible for contacting a sample of families who have been enrolled at least 6 months to assess customer satisfaction and at 11 months to advise them that their renewal information will be arriving and stress the importance of completing the form and returning it.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

A monthly report is generated by the State vendor, which captures insurance information of the families that disenroll from the program. This report captures both involuntary and voluntary disenrollment. However, this report does not break down how many obtained other public or private insurance. The retention unit is beginning to implement a disenrollment survey to all families who voluntarily and involuntarily withdraw from the NJ FamilyCare program.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

The mail-in application is a joint Medicaid and SCHIP application. For redetermination, the State Vendor has the capability to preprint the application with the latest information in their file. The beneficiary is then asked to correct or update that information. The County Boards of Social Services do not have that same capability to mail the pre-printed application asking the families to provide updated information relating to changes such as, changes in family composition and income. We have instructed the State Vendor and the County Boards of Social Services that the redetermination period for all Medicaid programs has been changed from 6 to 12 months. In addition, the County Boards of Social Services were instructed that no case be terminated before evaluating for continued eligibility using data available from other sources, such as the Food Stamp or Work First New Jersey programs.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

The state vendor screens all applicants for potential Medicaid eligibility. Those that involve children that are members of families already receiving Title XIX benefits through the County Boards of Social Service, or children who are eligible for a Medicaid program which can only be evaluated by the county agency are sent to the County

Boards of Social Services for an eligibility determination. The reverse is true if a family is evaluated at the County and is above 133% of the FPL (Medicaid expansion). This application will be sent to the State Vendor for an eligibility determination. The applications are sent to the County Board of Social Services or the State vendor making the process seamless to the family since a face-to-face interview is not necessary to enroll in the program.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes, the same delivery systems are used in Medicaid and SCHIP. There are five participating Health Maintenance Organizations for the delivery of health services.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

A monthly report is generated by the state vendor, which captures the number of children who are disenrolled for non-payment of premiums. These reports are currently being reviewed to assess if there has been any effect on participation in the program.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

*New Jersey has not assessed the effects of cost sharing on utilization of health services under SCHIP***.**

2.8 Assessment and Monitoring of Quality of Care:

Please see table 1.3 under the Objectives Related to Increasing Access to Care and Other Objectives/Health Outcomes.

SECTION 3. SUCCESSES AND BARRIERS

***This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers*.**

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility:

NA

B. Outreach:

NJ FamilyCare Program
Outreach Summary 2001

Multi media campaign

In October 2000, New Jersey began a statewide ad campaign with former Governor Whitman to promote the change from NJ KidCare to NJ FamilyCare. This campaign included network, cable and public television, print ads (dailies and minority newspapers and publications), radio announcements, transit and movie theatre ads. Offering a unique benefit incentive to potential applicants and adding even greater value and interest in NJ FamilyCare enrollment, we partnered with Friendly's restaurant and the State Aquarium. Families who applied for NJ FamilyCare prior to December 31, 2000 received a coupon for a free Friendly's ice cream cone and free admission to the State Aquarium. Within three (3) months NJ FamilyCare received 56,000 applications. Due to this incredible response to the program we halted all advertising. Even with the media campaign on hold the eligibility vendor was still receiving a high volume of applications.

Although the media campaign is on hold we have remained committed in partnerships we have developed to outreach families and assist in enrollment of eligible families with an *ongoing emphasis on reaching uninsured children.*

School Targeted Outreach:

Scholastic, Inc.

We are putting much of our focus into the schools and our partnership with Scholastic, Inc., a leading educational publisher in the nation and well recognized by professional educators. With the help of Scholastic, Inc., the Office of NJ FamilyCare was able to develop and implement a NJ FamilyCare outreach campaign in the schools. In Spring 2001 an in-school facilitator was established for over 1200 schools, who were responsible for getting NJ FamilyCare materials to the students in their building and ultimately home to their parents. As an incentive to encourage participation, the first 1,200 schools/day care centers to reply received a $150 gift certificate to Scholastic Incorporated. Our hope is to outreach the schools that did not participate in the Spring and give them the opportunity to participate in the Fall of 2001. We have found that you can reach the parents by approaching the students with colorful and engaging program materials. Scholastic created a database of all schools that responded, which they provided to NJ FamilyCare. This allows us not only the ability to see where our efforts have been successful, but gives us a "point person" in each school to whom future information and updates in the program can be sent.

Back to School Events
In August 2001 three Federally Qualified Health Centers and an area YMCA participated in Back-to School campaigns to outreach junior high school students for enrollment in NJ FamilyCare. Raffles for backpacks, school supplies and other prizes were provided. The outreach staff from each of the host organizations provided follow-up with the uninsured participants.

New Jersey State Interscholastic Athletic Association
Throughout the 2000-2001 school year, we did extensive outreach to school coaches and athletic personnel at the invitation of the New Jersey State Interscholastic Athletic Association (NJSIAA). We attended 14 coaches' clinics, where we had the opportunity to heighten the awareness of the availability of affordable insurance amongst coaches. NJ FamilyCare worked closely with the NJSIAA to develop a brochure geared toward athletes and coaches, which encourages uninsured families to enroll in the NJ FamilyCare program.

Free and Reduced Lunch
In September 2001, NJ FamilyCare was able to obtain the commitment and support of the Commissioner of Education in our efforts to reach uninsured children via the Free and Reduced Lunch application. He wrote a letter to superintendents and principals asking them to ensure that all parents who checked off the box requesting to learn more about NJ FamilyCare receive the needed information. He enclosed a NJ FamilyCare fact sheet with his letter, and instructed that it be duplicated and sent home to any interested family.

Corporate Partnerships:

McDonalds – *In August and September 2001 we participated in a McDonald, Inc. tri-state partnership with Pennsylvania and Delaware to promote the availability of affordable healthcare. McDonalds in these three states had messages on their tray liners, posters and happy meal inserts to promote healthy children and encourage enrollment. The national Insure Kids Now hotline number was clearly displayed. This corporate sponsorship was launched at a press event in August 2001.*

Kmart – *We Participated with the March of Dimes in "Make a Difference Day" by providing NJ FamilyCare program materials and outreach workers to 7 K-Mart locations throughout the State on Saturday, October 27, 2001. Flyers, pens, and band-aid* bookmarks were distributed, as well as applications to all those who requested them

Wal-Mart – *In February 2001 4 Wal-Mart stores statewide participated in the Babies First Sidekick promotion. NJ FamilyCare materials were displayed and made available to interested families.*

Grants:

Robert Wood Johnson – Covering Kids

The Robert Wood Johnson Foundation funded a three-year grant - through April 2002 - that focused on identifying the barriers involved in enrolling uninsured children in Medicaid and the NJ FamilyCare program. The grant "Covering Kids" focuses on how to implement solutions, alleviate barriers, and initiate outreach, enrollment, and educational programs through broad-based coalitions at state and local levels. The state worked closely with the lead agency, the Health Research and Educational Trust of NJ (HRET), to develop many successful outreach projects.

The "Covering Kids Project" in New Jersey operates through a statewide coalition of government and state-based organizations that promote innovative activities and involve child advocates to realize its goals. Along with the lead agency, the state-based organizations identified below collaborate with more than 28 other community-based organizations to successfully outreach and enroll eligible children:

- *La Salud Hispana*
- *St Joseph's Medical Center*
- *Gateway Maternal Child Health Consortium*
- *BCSB Family Life Development Center*
- *Tri-County Community Action Agency*
- *Association for Children of New Jersey*

Gateway Training's through RWJ/Covering Kids Grant

The Office of NJ FamilyCare provided training with Gateway Maternal Child Health Consortium. These trainings have drawn health care professionals from throughout the state of New Jersey to receive training on the NJ FamilyCare program. Since NJ FamilyCare subsumed NJ KidCare, the requests for attendance at these trainings has been overwhelming in every county. NJ FamilyCare has met the challenge of providing these sessions when and where they are needed, having trained over 2500 people thus far.

NJ FamilyCare Outreach Worker Training Manual

NJ FamilyCare and HRET developed a training manual and are now distributing it among all state and community based organizations that are spreading the word about NJ FamilyCare. The ultimate goal is to help parents in the enrollment process and increase enrollment of uninsured children. Within the established partnerships, and through NJ FamilyCare's links to more than 400 community-based organizations, private corporations, and foundations, we found a need for a resource for the outreach workers who help the eligible uninsured get enrolled in NJ FamilyCare.

The NJ FamilyCare Outreach Worker Training Manual is designed to complement our training programs and serve as a reference tool for trained outreach workers, as well as a train-the-trainer or self-instructing manual for new employees or those who may not be able to attend the one-day training. It includes a summary of the NJ FamilyCare eligibility guidelines, information on application completion, outreach tips and important

contact information. Also, sample outreach materials can be found in the pockets, along with an order form for requesting more copies. We hope that by assisting outreach workers, this resource guide makes the application process easier and more accessible for families, and eventually improves children's access to health insurance coverage.

Toolkits

NJ FamilyCare and HRET worked together on several other successful projects. ***Hospital outreach toolkits*** *were developed to encourage participation of hospital staff in identifying uninsured families and either referring them to application assistance sites, or assisting in the application process themselves. The toolkits include samples of NJ FamilyCare materials and ideas for more active hospital involvement. They were mailed to over 800 CEO's and VP Directors of departments of social work, admissions, discharge, billing, emergency, ambulatory/outpatient services and auxiliaries of all hospitals in New Jersey.*

The ***faith-based toolkit*** *was developed to encourage the participation of faith-based organizations and houses of worships in identifying uninsured families and referring them to an enrollment site for assistance. In addition to NJ FamilyCare materials, it includes tips on how to get the faith-based community involved, as well as sample sermons on child health and sample notices for the church bulletin board. This toolkit was mailed to over 1,500 faith-based organizations and houses of worship throughout the state.*

Directory of Application Assistance Sites

This directory, compiled by NJ FamilyCare and HRET, contained comprehensive information on the over four hundred application assistance sites throughout the state. Its purpose is to help outreach workers and human service agencies to direct families to sites near their homes where they can get help in applying for NJ FamilyCare. This directory is available with listings for the entire state, or by county. It was included in all the hospital and faith-based toolkits, as well as having been distributed to the offices of healthcare providers and other community sites.

Educational/Awareness Video

NJ FamilyCare participated in the development of this video with HRET in an effort to inform people about NJ FamilyCare and the importance of health insurance in meeting a family's healthcare needs. A National Basketball Association (NBA) spokesperson narrated the 5-minute video, which was recently completed in both English and Spanish, and will be distributed to WIC offices, hospital emergency rooms, pre/post natal birthing classes and primary care offices. Other possible viewing sites include unemployment offices, and closed circuit TV's in convenience stores.

Community Based Organization Grant

In July 1999, the NJ FamilyCare Outreach and Enrollment Campaign was initiated to maximize the potential participation of eligible uninsured children and families throughout New Jersey. Consideration was given to public and private provider entities

that have established links to families in the community. Realizing that families often turn to known and trusted community structures for guidance and assistance, NJ FamilyCare proposed to build upon existing community relationships, to make certain that uninsured families are identified and enrolled. This campaign successfully contracted with 41 Community Based Organizations (CBOs) including hospitals, faith-based, and school-based organizations.

Approximately $1 million was budgeted for this initiative for fiscal year 2000 and 2001. Awards in the amount of $25 are paid to the grantees for each successfully executed application resulting in enrollment in the NJ FamilyCare program. A one-time start-up award in the amount of $1,000 is made to each grantee selected to provide services. The purpose of these grants is to:

- *Identify eligible families and children that may qualify for NJ FamilyCare.*
- *Identify activities and programs that can support a specific plan for enrollment.*
- *Develop and implement new outreach methods that will identify potential NJ FamilyCare participants.*
- *Identify the full extent of assistance needed to help potential NJ FamilyCare eligibles in completing the NJ FamilyCare enrollment package, the application and all other required documentation.*

As of June 30, 2001 this grant was completed.

Current legislation allows incentives for schools, day care/child care centers, FQHC's, and local health departments to be paid a $25 incentive for assisting families in enrolling into the NJ FamilyCare program.

In addition, performance based agreements were entered into with other publicly funded programs. The agreements stated that the entities would "inreach" (search existing files) to identify and enroll children. Performance based agreements were reached with the Federally Qualified Health Centers (FQHCs), NJ Special Child Health Services, The Maternal Child Health Consortia, and Women, Infants, and Children Program (WIC).

Medical Support

The Office of NJ FamilyCare is working with the Office of Child Support on two projects, each of which received $50,000 grants from the Administration for Children and Families, as a result of application from New Jersey's Office of Child support and Paternity. The first is a model using existing data from both Child Support and Medicaid, to determine if children who are supposed to be receiving court ordered medical support are actually receiving it, and if they are covered, who is providing the coverage – private, employer, or publicly funded. A plan is being proposed to provide a coverage assessment form and a NJ FamilyCare application with the packet of information mailed to parties requesting modification of a support order.

The Office of NJ FamilyCare continues to work on a pilot project that began in February 2001 in Middlesex County. With the support of the County government and the Family Court Administrator, a NJ FamilyCare facilitator was placed outside of the hearing room on appropriate motion days. Hearing officers were given a brief training in NJ FamilyCare and asked to make sure that the parents of any uninsured child have spoken to the facilitator about applying for NJ FamilyCare. The facilitator gets the schedule for the day in advance, and tries to speak to all interested parties before they go into the hearings, as well as making herself available afterwards for questions and application assistance, if necessary.

Other Outreach:

Outreach to American Indians

New Jersey does not have any federally recognized tribes; however, the Office of NJ FamilyCare has outreached to the education coordinator of the Powhatan Renape Nation, who claim to service other tribes in New Jersey. Information regarding NJ FamilyCare was sent and an offer was extended to speak at one of their meetings.

Outreach Activities:

The activities listed below are the outreach events the State Office of NJ FamilyCare staff initiated and/or participated in during the reporting period.

Event Date	Event Name	Sponsor	
10/2/00	Children's Health Network	Paramus	Training
10/3/00	NJ FamilyCare training	Gateway - Hudson County	Training
10/4/00	NJ FamilyCare training	Millville public schools	Training
10/12/00	NJ FamilyCare training	Gateway - Salem County	Training
10/17/00	NJ FamilyCare training	Saint Barnabas Hospital	Training
10/18/00	NJ FamilyCare training	Saint Michaels Hospital	Training
10/26/00	NJ FamilyCare training	Gateway – Monmouth County	Training
11/8/00	NJ FamilyCare training	Gateway – Camden County	Training
11/9/00	NJ FamilyCare Presentation	SCHS – Red Bank	Presentation
11/16/00	NJ FamilyCare training	Gateway – Bergen County	Training
11/20/00	NJ FamilyCare training	Perth Amboy School nurses	Training
11/30/00	NJ FamilyCare training	Gateway – Ocean County	Training
12/12/00	NJ FamilyCare training	Gateway – Middlesex County	Training
01/10/01	Children Inter-Agency Coordinating Council	HSAC	Training
01/10/01	Safer Cities Initiative	Rutgers Law Center	Training
01/18/01	New BSR Training	NJDOL	Presentation
01/18/01	NJFC Presentation	Catholic Community Services	Presentation
01/23/01	NJFC Presentation	House of Faith Inc.	Presentation
01/24/01	NJFC Presentation	Community Coordinated Child Care	Presentation

01/25/01	NJFC Presentation	Southern Perinatal Cooperative	Presentation
01/26/01	Maximus Outreach & Enrollment Staff	DMAHS	Training
01/29/01	Human Services Advisory Council	Essex County	Training
01/29/01	NJFC Presentation	Camden Board of Education	Presentation
01/29/01	NJFC Presentation	Commission for the Blind	Presentation
02/01/01	NJ FamilyCare Training	NJPCA-NJSIAA	Training
02/02/01	Catholic Community Services	Diocese of Essex County	Training
02/03/01	NJFC Presentation	Community Coordinated Child Care	Presentation
02/06/-07/01	Branchburg (Elementary School Registration)	Branchburg SD	Exhibit
02/08/01	McDonald's Partnership	McDonald's	Presentation
02/08/01	NJ Football Coaches Clinic	NJPCA-NJSIAA	Exhibit
02/09/01	Girls Lacrosse Coaches Clinic	NJPCA-NJSIAA	Exhibit
02/12/01	NJFC Presentation	Perth Amboy Adult School	Presentation
02/13/01	Warren, Sussex, Hunter. Assoc. of Health Underwriters	NJ Association of Health Underwriters Chapters	Presentation
02/14/01	NJFC Presentation	Banking & Insurance	Presentation
02/14/01	Southern Jersey Community HealthCare	Community Healthcare Kick Off	Presentation
02/17/01	That's My Baby, Mom and I Fair	That's My Baby, Mom and I Fair	Exhibit
02/20/01	Children's Specialized Hospital	Children's Specialized Hospital	Presentation
02/20/01	Hamilton MS	Hamilton MS	Presentation
02/20/01	South Jersey Assoc. of Health Underwriters	NJ Association of Health Underwriters Chapters	Presentation
02/21/01	Covering Kids - NJHA	Covering Kids	Meeting
02/21/01	Thomas E. Bowe ES	Thomas E. Bowe ES	Exhibit
02/22/01	Our Lady of Lourdes Medical Center	Hospital Social Workers	Presentation
02/23/01	Cultural Days	MLK School Parent Advisory Council	Exhibit
02/24/01	Boys/Girls Tennis Coaches Clinic	NJPCA-NJSIAA	Exhibit
02/24/01	Boys/Girls Track Coaches Clinic	NJPCA-NJSIAA	Exhibit
02/26/01	Edgewater Manufacturing	Edgewater Manufacturing	Presentation
02/26/01	St. Barnabas Hospital System	Human Services Advisory Council of Essex County	Presentation
02/27/01	Burlington County Superintendent	Burlington County Superintendent	Superintendent's
02/27/01	South Jersey Assoc. of Health Underwriters	NJ Association of Health Underwriters Chapters	Presentation
02/28/01	School Based Youth Services	DHS Special Initiative	Presentation
02/28/01	Strength & Conditioning Clinic	NJPCA-NJSIAA	Exhibit
03/01/01	ARMDS	ARMDS	Presentation
03/05/01	Pediatric Asthma Coalition	Pediatric Asthma Coalition	
03/06-08/01	Covering Kids	Covering Kids	
03/07/01	Comfort Concepts, Inc.	Comfort Concepts, Inc.	Presentation
03/08/01	NJFC Legislative Training	Gateway MCH	Training
03/10/01	HomeCare Options Inservice	HomeCare Options	Presentation
03/10/01	Statewide Parent Advocacy Network Conference (SPAN	SPAN	Exhibit
03/12/01	Medical Students at UMDNJ	Extensions	Training
03/13/01	AARP/Party Rental	AARP/Party Rental	Presentation
03/14/01	NJFC Presentation	Vineland Public Schools	Presentation
03/14/01	The Children Interagency Coordinating Council	The Children Interagency Coordinating Council	Presentation
03/15/01	NJ FamilyCare Presentation	Public School #17	Presentation
03/15/01	NJFC Legislative Training	Gateway MCH	Training
03/20/01	EITC	Human Services Advisory Council	Presentation
03/25/01	Health Fair	National Kidney Foundation	Exhibit
03/28/01	NJ FamilyCare Training	Gloucester County Office of Education	Training
04/01/01	Boys/Girls Soccer Coaches Clinic	NJPCA-NJSIAA	Exhibit
04/03/01	NJ FamilyCare Training	The People Care Center	Training
04/04/01	HomeCare Options Inservice	HomeCare Options	Presentation
04/05/01	NJ FamilyCare Training	Brick Health System Medical	Presentation
04/07/01	Healthy Kids Day	AmeriGroup	Exhibit

04/09/01	Nurses Training	Schering-Plough/Childhood Asthma	Presentation
04/10/01	Gateway - NJ FamilyCare Training	St. Elizabeth College	Training
04/17/01	NJ FamilyCare Presentation	Rick's Bus Company	Presentation
04/18/01	NJ FamilyCare Presentation	St. Joe's Hospital	Presentation
04/19/01	United Way Essex	United Way Essex	Presentation
04/22/01	New Jersey Primary Care Association	NJPCA-NJSIAA	Presentation
04/25/01	NJ Camping Association	NJ Camping Association	Exhibit
04/26/01	Community Awareness Dinner	Central NJ Maternal & Child Health Consortium, Inc	
04/26/01	NJ FamilyCare Training	St. James Episcopal Church	Training
04/28/01	NJ FamilyCare Presentation	Visiting Health Services - Union County	Presentation
05/04/01	Wrestling Coaches Clinic	NJPCA-NJSIAA	Exhibit
05/05/01	Health Fair	Rosedale Baptist Church	Exhibit
05/05/01	Health Fair	Rancocas Hospital & Burl Co Prosecutor's Office	Exhibit
05/07/01	NJ Association of School Social Workers Conference	NJ Association of School Social Workers Conference	Exhibit
05/11-12/01	LVA-NJ Conference - NJ	LVA-NJ	Exhibit
05/12/01	Health Fair	Rancocas Hospital & Burl Co Prosecutor's Office	Exhibit
05/16/01	Health Fair	Gregory Elementary School	Exhibit
05/16/01	Trainers Workshop	NJPCA-NJSIAA	Presentation
05/18-19/01	NJ 11th Annual Statewide Home Educator's Convention	ENOCH of New Jersey	Exhibit
05/18/01	Healthy Start-Male Initiative	Ramada Inn-National Conference Center	Exhibit
05/23/01	Health Fair	BCCAP Head Start Health Fair	Exhibit
05/24/01	4th Opportunity Network Fair	Hudson County Officials	Exhibit
05/24/01	Health Fair	BCCAP Head Start Health Fair	Exhibit
05/25/01	Health Fair	BCCAP Head Start Health Fair	Exhibit
05/25/01	Health Fair	BCCAP Head Start Health Fair	Exhibit
05/25/01	Health Fair	BCCAP Head Start Health Fair	Exhibit
05/30/01	Displaced Homemakers Conference	State Employment & Training Commission	Conference
05/30/01	NJ FamilyCare Training	Gateway	Training
05/30/01	Women in Workforce	Labor	Exhibit
05/31/01	NJ FamilyCare Training	Gateway	Training
06/13/01	PTO Health Fair 2001	Granville Charter School	Exhibit
06/20/01	NJFC Presentation	AAHAM - American Assoc. Healthcare..	Presentation
06/22/01	NJ FamilyCare Training	Gateway	Training
06/23/01	KlaasKids Digital Fingerprint-a-thon Promotion	KlaasKids Foundation	Exhibit
07/15/01	NJ FamilyCare Presentation	St. Michael's Medical Center	Presentation
07/27-29/01	Morris County 4-H Fair	Morris County 4-H Association	Exhibit
07/29/01	Annual Health Fair & Picnic	NAACP - Trenton Branch	Exhibit
08/11/01	Health Fair	Carteret Community Health Event-Senator Vitelli	Exhibit
08/11/01	Ocean Twp. Founder's Day	Ocean Twp. Founders Day Committee	Exhibit
08/23/01	Training	Bayada Nurses	Training
08/23/01	UMDNJ	UMDNJ-Newark	Training
08/25/01	Health Fair	UMDNJ	Exhibit
09/08/01	City of Carteret Ethnic Day & Craft Fair	City of Carteret	Exhibit
09/13/01	Avalon Health Fair	Avalon Municipal Alliance	Exhibit

C. Enrollment:

As of September 30, 2001, 79,994 children were enrolled in NJ FamilyCare. Our biggest challenge continues to be enrollment of our Plan D children. These are children in families with income from 201% of the FPL to 350% of the FPL. Our current marketing and outreach efforts through the schools are focusing on this target population.

D. Retention/disenrollment:

Please see section 1.1

E. Benefit structure:

N/A

F. Cost-sharing:

N/A

G. Delivery system:

Please see section 1.1

H. Coordination with other programs:

NJ FamilyCare has been successful in coordinating with many publicly funded programs. We work closely with program in the Department of Health and Senior Services, such as, WIC, Special Child Health Services, Maternal Child Health Consortia's, and Local Health Departments. These programs have been extremely active in outreaching and enrolling eligible families.

I. Crowd-out:

Please see section 2.3

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2000 starts 10/1/00 and ends 9/30/01).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care	$157,512,000	$173,264,000	$190,590,000
Per member/per month rate X # of eligibles			
Fee for Service	27,864,000	30,651,000	33,716,000
Total Benefit Costs	$185,376,000	$203,915,000	$224, 306,000
(Offsetting beneficiary cost sharing payments)	(5,200,000)	(5,720,000)	(6,292,000)
Net Benefit Costs	$180,176,000	$198, 195,000	$218,014,000
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs			
10% Administrative Cost Ceiling	16,423,000	18,065,000	19,871,000
Federal Share (multiplied by enhanced FMAP rate)	127,789,000	140,569,000	154,625,000
State Share	68,810,000	75,691,000	83,260,000
TOTAL PROGRAM COSTS	$196,599,000	$216,260,000	$237,885,000

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

The total State expenditures for family coverage during federal fiscal year 2001 were $100,885,028.

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__ State appropriations
_____ County/local funds
_____ Employer contributions
__X__ Foundation grants – *Robert Wood Johnson Foundation – "Covering Kids" grant*
__X__ Private donations (such as United Way, sponsorship)
_____ Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No anticipated changes.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	NJ FamilyCare Plan A	NJ FamilyCare Plan B, C, and D
Provides presumptive eligibility for children	_____No **X** Yes, for whom and how long? *Children in families with income up to 133% FPL, PE period lasts from the date of service to the end of the following month*	_____No **X** Yes, for whom and how long? *Children in families with income up to 200% FPL, PE period lasts from the date of service to the end of the following month*
Provides retroactive eligibility	_____No **X** Yes, for whom and how long? *Eligibility applies back to the first day of the month of application for children in families with income below 133% FPL. Retroactive eligibility is available to cover unpaid medical bills for the three months prior to the month of application, from Medicaid approved providers, if the requirements for eligibility are met in each of the three months.*	**X** No _____Yes, for whom and how long?
Makes eligibility determination	**X** State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff	_____State Medicaid eligibility staff **X** Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
	_____Other *(specify)*	
Average length of stay on program	Specify months **N/A**	Specify months **N/A**
Has joint application for Medicaid and SCHIP	_____No **X** Yes	_____No **X** Yes
Has a mail-in application	_____No **X** Yes	_____No **X** Yes
Can apply for program over phone	_____No **X** Yes, *documentation must be submitted*	_____No **X** Yes, *documentation must be submitted*
Can apply for program over internet	_____No **X** Yes, *Application can be downloaded off the NJ FamilyCare website*	_____No **X** Yes, *Application can be downloaded off the NJ FamilyCare website*
Requires face-to-face interview during initial application	**X** No _____Yes	**X** No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	**X** No _____Yes, specify number of months What exemptions do you provide?	_____No **X** Yes, specify number of months **6 months** What exemptions do you provide? *Under NJ FamilyCare Plans B, C, and D the six-month waiting period still applies to those children who are covered under an employer-sponsored group plan. As of July 1, 1999 the waiting period was eliminated for families purchasing health care coverage from an individual plan or COBRA. These families income must be at or below 200 percent of the FPL. Also, exceptions will be made to the six-month requirement:* • *If prior employer coverage was*

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
		lost through no fault of the family, such as, an employer went out of business or the employee was laid off or changed jobs. • *However, if the caregiver changed jobs and is eligible for group insurance at the new job it must be more expensive than the NJ FamilyCare rate.* • *If the family's income is between 200-350% of the federal poverty level, and their COBRA benefits expired.*
Provides period of continuous coverage regardless of income changes	**X** No _____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	**X** No _____Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	**X** No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	_____No **X** Yes, how much*? Plan C - $15, Plan D $30-$100* Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship **X** Other (specify) *the family is billed, and we do not monitor who actually makes the payment.*
Imposes copayments or coinsurance	**X** No _____Yes	_____No **X** Yes, *Plans C & D $5-$35*
Provides preprinted redetermination process	_____ No **X** Yes, *the family is sent an application with their information precompleted along with a self addressed stamped envelope.*	_____ No **X** Yes, *the family is sent an application with their information precompleted along with a self addressed stamped envelope.*

5.2 Please explain how the redetermination process differs from the initial application process.

The renewal process differs from the initial application only insofar as it is a more passive process for applicants. In most cases, the family is sent a pre-printed application, which includes name, address, and family composition, they are asked to simply re-verify information, which is not likely to change, and to update any information that has changed, for example, one month of income and household size. For the family's convenience a self-addressed stamped envelope is included, which is specially coded for easy identification.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

Note: For section 1931 the income limit did not change, but an earned income disregard was added which is the difference between the AFDC payment standard in effect 7/16/96 and 133% of the FPL

185% of FPL for children under age **1**
133% of FPL for children aged **1 thru 5**
100% of FPL for children aged **6 thru 18**

Medicaid SCHIP Expansion

133% of FPL for children aged **6 thru 18 if uninsured**

Separate SCHIP Program

200% of FPL for **all children up to 19**
350% of FPL for **all children up to 19 (**income between 200% and 350% is disregarded)

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes **X** No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$90	$90	$0
Self-employment	$90	$90	$0
Alimony payments Received	$0	$0	$0
Paid	All	All	$0
Child support payments Received	$50	$50	$0
Paid	All	All	$0
Child care expenses	See below*	See below*	$0
Medical care expenses	$0	$0	$0
Gifts	$0	$0	$0
Other types of disregards/deductions (specify)	N/A	N/A	Plan D disregard for all income 200%-350%

* $175/mo per child age two or older, or incapacitated adult, for all full time employment.

$200/mo per child under age two, for full time employment

$135/mo per child age two or older, or incapacitated adult, for part time employment

$150/mo per child under age two, for part time employment

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

X No___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

X No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

X No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes **X** No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

A. Family coverage:

As stated earlier in Section 2.1 the original design of the NJ FamilyCare program was to provide free or low cost health insurance to 125,000 uninsured adults over a three-year period. As of September 30, 2001 NJ FamilyCare has enrolled a staggering 92,662 parents/caretakers. This enormous response to the program resulted in a large backlog of applications, which created challenges to DMAHS. Over the course of this reporting period the Division of Medical Assistance and Health Services (DMAHS) worked closely with Maximus, the eligibility vendor, to address the large backlog of applications and instituted the regular monitoring of the eligibility determination process and the call center. New Jersey's focus for the coming year will be to continue the careful monitoring of actions already taken and developing and evaluating other strategies to help ensure we are within budget constraints, applications are being processed timely, and families are receiving adequate information from our toll free hotline. New Jersey's commitment remains firm to enroll all eligible parents and children into NJ FamilyCare.

B. Employer sponsored insurance buy-in:

See section 2.2

C. 1115 waiver:

No change

D. Eligibility including presumptive and continuous eligibility:

As of November 1, 2001 the New Jersey Health Access program was discontinued. All current Health Access recipients were given the opportunity to enroll in the NJ FamilyCare program. The Health Access program was started in 1995. This program was solely a state funded program that provided heavily subsidized insurance to families and individuals who had been uninsured for a maximum of 12 months and had an income at or below 250% of the federal poverty level. According to the information on file, 1800 Health Access recipients were eligible to enroll in the NJ FamilyCare program. As of the end of November 2001, a total of 1200 individuals have been enrolled in NJ FamilyCare. Because the two programs are slightly different in their income criteria, all Health Access recipients will be screened for NJ FamilyCare. If they are over the NJ

FamilyCare limits but are still within the income guidelines for Health Access, they will be enrolled in NJ FamilyCare, but will have an identifier and will only be paid for with the use of state funds.

E. Outreach:

No change

F. Enrollment/redetermination process:

No change

G. Contracting:

As of August 2002 NJ FamilyCare's contract with Star Group, the advertising agency, will end. The Department of Human Services is currently reviewing the necessity of retaining an advertising contractor in the future.